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In the Supreme Court of the United States

OCTOBER TERM, 1997

KIMBERLY BELSHÉ, DIRECTOR, CALIFORNIA DEPARTMENT OF HEALTH SERVICES, PETITIONER

v.

ORTHOPAEDIC HOSPITAL, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

SETH P. WAXMAN
Solicitor General
FRANK W. HUNGER
Assistant Attorney General
EDWIN S. KNEEDLER
Deputy Solicitor General
LISA SCHIAVO BLATT
Assistant to the Solicitor General
ANTHONY J. STEINMEYER
JEFFREY CLAIR
Attorneys
Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

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QUESTIONS PRESENTED

1. Whether hospital providers may bring an action under 42 U.S.C. 1983 to challenge a State's Medicaid plan on the ground that it fails to consider providers' costs, in purported violation of 42 U.S.C. 1396a(a)(30)(A).

2. Whether 42 U.S.C. 1396a(a)(30)(A) requires State Medicaid agencies to set hospital outpatient reimbursement rates that bear a reasonable relationship to efficient and economical hospital costs of providing quality services.

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This brief is submitted in response to the Court's order inviting the Solicitor General to file a brief expressing the views of the United States.[1]

STATEMENT

1. The Medicaid program established in 1965 by Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.*, is a cooperative federal-state program to provide medical care

[1] The United States has a significant financial stake in the interpretation of 42 U.S.C. 1396a(a)(30)(A). By law, the federal government provides between 50% and 83% of a State's cost of patient care, as determined by a formula keyed to per capita income in the State. See 42 U.S.C. 1396d(b). In fiscal year 1996 alone, the federal contribution to the Medicaid program for medical assistance totalled approximately $88 billion, making Medicaid one of the largest items in the federal budget. Of that amount, some $8 billion was provided to California. See Health Care Financing Admin., Dep't of Health and Human Services, *Medicaid Financial Management Report Fiscal Year 1996* (1997).

to needy individuals. *Wilder* v. *Virginia Hospital Ass'n*, 496 U.S. 498, 502 (1990); *Atkins* v. *Rivera*, 477 U.S. 154, 156 (1986). State participation in Medicaid is voluntary, but those States that elect to participate must comply with requirements imposed by the Medicaid Act and by the Secretary of Health and Human Services in her administration of the Act. See 42 U.S.C. 1396a; *Wilder*, 496 U.S. at 502; *Rivera*, 477 U.S. at 157. Within those basic limits, however, each State enjoys great flexibility in both designing and administering its own program.

To qualify for federal funds, participating States must submit to the Secretary, and receive approval of, "a plan for medical assistance" detailing the nature and scope of the State's Medicaid program. 42 U.S.C. 1396a(a); 42 C.F.R. 430.10 (1996); *Wilder*, 496 U.S. at 502. Among other requirements, a State's plan must

> provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan * * * as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. 1396a(a)(30)(A).

In implementing Section 1396a(a)(30)(A), the Secretary has not required States to adopt any particular methodology or rate-making procedures to provide for payments for services under the Act. The Secretary has, instead, sought to preserve maximum flexibility for the States to set Medicaid payment rates. Accordingly, the Secretary does not dictate what level of payments will "assure * * * efficiency, economy, and quality of care" or

be sufficient to provide for equal access to such care and services. See 42 C.F.R. 447.204. Nor does the Secretary require the States to adopt any particular procedure or methodology for determining whether payments are "necessary" to meet the general criteria in 42 U.S.C. 1396a(a)(30)(A), or require that the payments be made at rates that will enable providers to recover their full costs of furnishing covered services. Rather, the Secretary requires States to achieve the desired outcomes of equal access and quality of care.

2. In August 1990, respondents, a hospital and an association of health care providers, filed suit against petitioner in the United States District Court for the Central District of California, alleging that the State of California's Medicaid rates for outpatient services furnished by hospitals do not meet the requirements of Section 1396a(a)(30)(A).[2] California's Medicaid plan provides that hospitals rendering such outpatient services will be paid the lower of their usual charges or a prospectively-determined flat rate for the particular type of outpatient service. Pet. App. A7, B3-B4.

On October 6, 1992, the district court entered its order on the parties' motions for summary judgment. Pet. App. B5. The district court first ruled that respondents had a federal cause of action under 42 U.S.C. 1983. *Id.* at B7. The court also held that California had failed adequately to consider whether its payments for certain outpatient hospital services were consistent with the statutory standards of "efficiency, economy, and quality of care," and the court therefore remanded the matter to petitioner for further consideration of its Medicaid rates. *Id.* at B5-B6.

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[2] Outpatient hospital services are "preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished to outpatients" under the direction of a physician or dentist by an institution licensed as a hospital. See 42 C.F.R. 440.20(a).

On remand, the State conducted a study of its existing rate structure and held a public hearing. On April 15, 1994, the State readopted its previous reimbursement levels. Respondents thereafter refiled suit in the district court to challenge the readopted rates. On March 20, 1995, the district court held that California's payment rates complied with Section 1396a(a)(30)(A). Pet. App. B1-B26. As an initial matter, the court reaffirmed its earlier holding that respondents have a cause of action under Section 1983 to enforce Section 1396a(a)(30)(A). *Id.* at B7-B9.[3]

On the merits, the court rejected respondents' contention that the "efficiency, economy, and quality of care" criteria in Section 1396a(a)(30)(A) require California to base reimbursement of hospitals on their costs of providing services. The court concluded that "[p]ayments do not have to be sufficient to reimburse hospitals for their costs, but need only be sufficient to ensure access." Pet. App. B14. Noting that "[t]he statute was enacted as a cost-containment measure," the court concluded that as long as Medicaid recipients have access to quality care, "it is irrelevant whether hospitals make or lose money treating [Medicaid] beneficiaries." *Id.* at B15, B16. Finally, the court ruled that petitioner had adequately considered the factors of "efficiency, economy, and quality of care" in setting its payment rates for outpatient services, and that its

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[3] The court reconsidered the cause-of-action issue in light of this Court's intervening decision in *Suter* v. *Artist M.*, 503 U.S. 347 (1992), and Congress's subsequent enactment of Section 211 of the Social Security Act Amendments of 1994, Pub. L. No. 103-432, 108 Stat. 4460, which addresses the enforceability of Social Security Act provisions that specify the contents of a "State plan." See 42 U.S.C. 1320a-2 and 1320a-10. Reasoning that Section 211 requires courts to assess the enforceability of "State plan" provisions under the standards articulated in *Wilder* v. *Virginia Hospital Association*, 496 U.S. 498 (1990), the court "disregard[ed] *Suter*" and reaffirmed its earlier holding. Pet. App. B9.

rates were rationally related to those statutory criteria. *Id.* at B16-B25. The Court therefore entered summary judgment in favor of petitioner. *Id.* at B25.

3. The court of appeals reversed. Pet. App. A1-A22. It held that petitioner "must set hospital outpatient reimbursement rates that bear a reasonable relationship to efficient and economic hospitals' costs of providing quality services, unless [the State] shows some justification for rates that substantially deviate from such costs." *Id.* at A13. The court reasoned that the State "cannot set rates consistent with efficiency and economy in the health care system without considering the costs to the hospitals that provide most of the services." *Id.* at A14.

The court of appeals recognized that "[s]ome of the services provided by hospital outpatient departments could be provided more economically by non-hospital providers such as freestanding clinics or doctors' offices because those providers have lower fixed costs than do hospitals." Pet. App. A6. The court nonetheless rejected the State's argument that it would be neither efficient nor economical to set payment rates that compensate hospitals for the higher costs they incur in providing the same services. Observing that the Medicare Act requires hospitals participating in that program to provide emergency room services, *id.* at A17 (citing 42 U.S.C. 1395dd), the court reasoned that "the majority of outpatient services are in fact provided in hospitals, and that the majority of hospital outpatient services are in the emergency room." *Id.* at A20. The court also pointed out that, "[w]ith no incentive to use the most economical provider, [Medicaid] beneficiaries frequently choose the more accessible and convenient hospital outpatient departments over less costly facilities, some of which may be entirely unavailable or less available to them." *Id.* at A6-A7.

Against this background, the court concluded that the State "cannot ensure access by relying on regulations requiring hospitals to treat patients in the emergency room, and then refuse to pay the cost of such treatment because theoretically it could have been provided more efficiently elsewhere." Pet. App. A20-A21. Thus, in the court's view, notwithstanding the fact that "[i]n this case there has been no assertion of a provider participation problem," *id.* at A17, the State "must undertake to determine what it costs an efficient hospital economically to provide quality care," *id.* at A18.

Because the State "did not base its readoption of existing rates on the conclusion that they adequately reimburse provider costs," the court of appeals concluded that the readopted rates were arbitrary and capricious. Pet. App. A22. The court therefore remanded the case to petitioner to "undertake responsible cost studies that will provide reliable data as to the hospitals' costs in providing outpatient services," with the State "bearing the burden of justifying any rate that substantially deviates from such determined costs." *Ibid.*

DISCUSSION

We agree with petitioner that the court of appeals erred in reading Section 1396a(a)(30)(A) as imposing on States an obligation to set payment rates for outpatient services that "substantially reimburse providers their costs." Pet. App. A19. We also agree with petitioner that the respondent hospitals do not have a cause of action under 42 U.S.C. 1983 to challenge reimbursement rates as inconsistent with Section 1396a(a)(30)(A). Those two issues are interrelated and raise important questions regarding the flexibility of the States in designing their Medicaid reimbursement rates. Although there is no square conflict on those issues, they may well warrant review by this Court at some point. Petitioner, however, did not preserve below,

and the court of appeals therefore did not address, the threshold question of whether respondents have a right of action under 42 U.S.C. 1983. Accordingly, and because of other developments, this case would not be an appropriate vehicle for plenary consideration of whether hospitals have a right of action under Section 1983 or whether the court of appeals correctly interpreted Section 1396a(a)(30)(A).

1. The court of appeals construed Section 1396a(a)(30)(A) to *require* States to make Medicaid payments for outpatient services so that a particular class of providers of those services—hospitals—are reimbursed for their costs. In our view, that interpretation misreads the plain language of Section 1396a(a)(30)(A) and frustrates that Section's purpose of giving States wide discretion to set Medicaid payments that are consistent with efficiency, economy, and access to quality care.

a. The Medicaid Act defines the "medical assistance" provided under the Act to mean "payment of *part* or all of the cost" of the covered service. See 42 U.S.C. 1396d(a) (emphasis added). Thus, there is no general mandate under Medicaid to reimburse providers for all or substantially all of their costs. Moreover, in directing States to make Medicaid payments that "are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area," the text of Section 1396a(a)(30)(A) does not require States to set rates that reimburse hospitals in particular for their costs of providing outpatient (or other) services. The focus of the Section is instead on the availability of services generally. The court of appeals' contrary holding, that States must reimburse providers at

rates that essentially ensure recovery of their costs, is therefore incorrect.

Indeed, when Congress has intended to require States to base Medicaid reimbursement rates on the costs incurred in providing a particular service, it has said so expressly in the text of the Act. For example, the Boren Amendment to the Medicaid Act (42 U.S.C. 1396a(a)(13)(A)), which was at issue in *Wilder* v. *Virginia Hospital Ass'n*, 496 U.S. 498 (1990), but has recently been repealed (see pages 19-20, *infra*), required States to make payments based on rates that "are reasonable and adequate *to meet the costs which must be incurred* by efficiently and economically operated facilities" providing inpatient hospital, skilled nursing, and other institutional services. 42 U.S.C. 1396a(a)(13)(A) (emphasis added); *Wilder*, 496 U.S. at 502-503. See also 42 U.S.C. 1396a(a)(13)(E) (requiring Medicaid plan to pay 100 percent of the *reasonable costs* of providing covered services in a rural health clinic or federally qualified health center) (emphasis added). By contrast, Section 1396a(a)(30)(A) does not set forth any requirement that a State consider costs in making payments for outpatient or other services, much less that a State fully reimburse a hospital's higher costs in furnishing such services. That omission is persuasive evidence that Section 1396a(a)(30)(A) does not require a State to do so. See *Field* v. *Mans*, 516 U.S. 59, 67 (1995) ("an express statutory requirement here, contrasted with statutory silence there, shows an intent to confine the requirement to the specified instance").

In accord with the text and structure of the Medicaid Act, the Secretary has not construed Section 1396a(a)(30)(A) to require the States to base reimbursement rates for outpatient or other services on the costs incurred by hospitals or other categories of providers. Rather, implementing regulations leave the States broad

discretion to set rates, provided that they do not exceed the rates that would be paid by Medicare for comparable services or the prevailing charges for comparable services within the pertinent locality. 42 C.F.R. 447.304(a). Those regulations reflect the Secretary's view that Section 1396a(a)(30)(A) gives States substantial flexibility to set Medicaid payments that are efficient and economical, and enlist sufficient providers for Medicaid recipients to have access to quality care. See *Methodist Hospitals, Inc.* v. *Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996) (Section 1396a(a)(30)(A) "requires each state to produce a *result*, not to employ any methodology for getting there," and absent proof that a rate structure results in inadequate access, States "may say what they are willing to pay and see whether this brings forth an adequate supply"); *Minnesota Homecare Ass'n* v. *Gomez*, 108 F.3d 917, 918 (8th Cir. 1997) (Section 1396a(a)(30)(A) "does not require the State to utilize any prescribed method of analyzing and considering [the statutory] factors"); cf. *Alexander* v. *Choate*, 469 U.S. 287, 303 (1985) ("The [Medicaid] Act gives the States substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage, as long as care and services are provided in 'the best interest of the recipients.'") (quoting 42 U.S.C. 1396a(a)(19)).[4]

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[4] The decision below also is inconsistent with the history of Section 1396a(a)(30)(A). As originally enacted, it directed the States to "assure that payments * * * are not *in excess of reasonable charges* consistent with efficiency, economy, and quality of care." Social Security Amendments of 1967, Pub. L. No. 90-248, § 237(b), 81 Stat. 911 (emphasis added). See also H.R. Conf. Rep. No. 1030, 90th Cong., 1st Sess. 66-67 (1967). In 1981, Congress deleted the "reasonable charge" limitation, in response to complaints that it imposed burdensome administrative requirements on state Medicaid agencies and hampered their ability to try innovative, more cost-effective approaches to provider reimbursement. See Omnibus Reconciliation Act of 1981, Pub. L. No. 97-35, § 2174(c), 95 Stat. 809; H.R. Rep. No. 158, 97th Cong., 1st

b. The court of appeals based its decision that Section 1396a(a)(30)(A) mandates States to consider providers' costs on its apparent understanding that the Medicare Act, in 42 U.S.C. 1395dd, effectively requires hospitals to provide outpatient services to Medicaid beneficiaries who request them. Pet. App. A6, A17. That is incorrect. The Medicare Act requires only that a hospital participating in the Medicare program determine whether a patient has an emergency condition, and that the hospital treat or stabilize the patient if an emergency condition is diagnosed. 42 U.S.C. 1395dd. It does not require hospitals to provide any patients with *non*-emergency care, such as diagnostic, therapeutic, or rehabilitative services, that is provided on an outpatient basis.[5]

The court below similarly erred in assuming that hospitals generally cannot participate in the program in numbers sufficient to ensure adequate access to quality care

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Sess. Pt. 2, 312 (1981). The deletion was intended to "allow States to be more creative and offer incentives for improved delivery of care under their programs." *Id.* at 313. Congress, moreover, intended that the amendment would "reduce Federal outlays in Medicaid * * * in a manner which * * * provides the States with flexibility to institute a number of measures in their programs to reduce cost and make them more efficient." *Id.* at 279. Indeed, the court below recognized (Pet. App. A16) that "Congress intended payments to be flexible within a range; payments should be no higher than what is required to provide efficient and economical care, but still high enough to provide for quality care and to ensure access to services."

[5] Hospitals are not required by federal law to provide the full range of Medicaid-covered services to any beneficiary who seeks treatment. *Barney* v. *Holzer Clinic, Ltd.*, 110 F.3d 1207, 1211-1212 (6th Cir. 1997). Rather, participation in the Medicaid program is voluntary, and providers are obligated to offer only such non-emergency care to Medicaid recipients as they are willing to undertake. See 42 U.S.C. 1396a(a)(23); 42 C.F.R. 431.51(b)(1)(ii). Thus, to the extent respondents are providing access to outpatient care under the rates they challenge, it is not because they are compelled by federal law to do so.

unless payment rates meet the full costs incurred by efficient hospitals. Pet. App. A14-A17. To be sure, reimbursement levels affect provider participation rates. See generally D. Lewis-Idema, *Increasing Provider Participation* 11-17 (Nat'l Governors' Ass'n 1988). There is no clear evidence, however, that Medicaid must assume all or substantially all of the costs incurred by hospitals in order to ensure reasonable access to quality care. Factors other than a State's basic Medicaid payment rates significantly affect provider participation.[6] Moreover, a hospital may have a sufficient economic incentive to provide care to Medicaid recipients as long as its marginal revenue from treating additional Medicaid patients offsets its marginal costs of doing so, even if the hospital does not fully recover a pro rata portion of its total costs. Recognition of that reality in establishing reimbursement rates for outpatient services under Medicaid is fair and reasonable, because the higher costs incurred by hospitals may be attributable to services other than non-emergency outpatient services—such as furnishing inpatient and emergency care, the core mission of most hospitals.

This case in fact confirms that reimbursement of substantially all of providers' fully allocated costs is not necessary to ensure adequate access to quality care. Although California does not fully reimburse such costs of

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[6] For example, Medicaid requires that hospitals that serve a disproportionate number of low-income patients receive additional payments to compensate for the added costs incurred in serving such populations. 42 U.S.C. 1396a(a)(13)(A), 1396r-4(a). Similarly, some States have established special funds to compensate providers for the costs of providing uncompensated or undercompensated care. See, *e.g*, *New England Health Care Employees Union* v. *Mount Sinai Hospital*, 65 F.3d 1024 (2d Cir. 1995). Some providers may also be able to defray uncompensated costs by increasing charges to paying patients who have private insurance. See, *e.g.*, *New York Conf. of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 658-660 (1995).

outpatient services for a majority of hospitals participating in its Medicaid program, Pet. App. A10, it has not been demonstrated that recipients lack adequate access to providers of outpatient services. Indeed, the court of appeals acknowledged that "[i]n this case there has been no assertion of a provider participation problem." *Id.* at A17.

c. The decision below also conflicts with Congress's clear intent to encourage cost-efficient provision of covered Medicaid services. The court of appeals did not dispute that "[s]ome of the services provided by hospital outpatient departments could be provided more economically by non-hospital providers." Pet. App. A6. Thus, in holding that petitioner must set rates sufficient to reimburse costs incurred specifically by hospitals, the decision below effectively requires petitioner to establish rates of payment that perpetuate inefficient patterns of utilization merely because such inefficiencies have become entrenched in the marketplace. That conclusion is inconsistent with Section 1396a(a)(30)(A)'s directive that States set payments that are "consistent with efficiency [and] economy."

2. Petitioner also requests the Court to consider whether providers have a cause of action under 42 U.S.C. 1983 to challenge rates as inconsistent with Section 1396a(a)(30)(A). Although we agree with petitioner that providers have no such right, that issue does not warrant plenary review in its own right, especially in this case.

a. Every court that has considered the issue has held that providers have a right of action under Section 1983 to enforce 42 U.S.C. 1396a(a)(30)(A). *Methodist Hospitals, Inc.* v. *Sullivan*, 91 F.3d at 1029; *Arkansas Medical Society, Inc.* v. *Reynolds*, 6 F.3d 519, 528 (8th Cir. 1993); *Visiting Nurse Ass'n of North Shore, Inc.* v. *Bullen*, 93 F.3d 997, 1002-1006 (1st Cir. 1996), cert. denied, 117 S. Ct.

955 (1997).[7] Those decisions have relied on this Court's decision in *Wilder*, which held that the Boren Amendment, 42 U.S.C. 1396a(a)(13)(A), "create[d] a right enforceable by health care providers under [Section] 1983 to the adoption of reimbursement rates that are reasonable and adequate to meet the costs of an efficiently and economically operated facility that provides care to Medicaid patients." 496 U.S. at 509-510.

We do not believe, however, that this Court's decision in *Wilder* resolves the question whether Congress, in enacting Section 1396a(a)(30)(A), similarly intended to create rights enforceable under Section 1983. The Boren Amendment mandated that a State provide for payments "through the use of rates * * * which * * * are reasonable and adequate to *meet the costs which must be incurred* by efficiently and economically operated facilities." 42 U.S.C. 1396a(a)(13)(A) (emphasis added). In contrast, Section 1396a(a)(30)(A) does not specifically require that the State consider providers' costs in setting Medicaid payments, much less "meet" those costs; it simply requires that a State provide for "methods and procedures relating to the * * * payment for care and services * * * as may be necessary * * * to assure that payments are consistent with efficiency, economy, and quality of care" and "sufficient to enlist enough providers" so that there will be equal access to care and services for Medicaid patients.

In order for an Act of Congress to create rights enforceable under Section 1983, "Congress must have intended

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[7] See also *Sobky* v. *Smoley*, 855 F. Supp. 1123, 1137-1138 (E.D. Cal. 1994); *Illinois Hospital Ass'n* v. *Edgar*, 765 F. Supp. 1343, 1349 (N.D. Ill. 1991). Cf. *Fulkerson* v. *Comm'r, Maine Dep't of Human Servs.*, 802 F. Supp. 529, 533-535 (D. Maine 1992) (concluding that Medicaid recipients have right under 42 U.S.C. 1983 to enforce Section 1396a(a)(30)(A)'s equal access provision, but not its requirement that payments be consistent with "efficiency, economy and quality of care").

that the provision in question benefit the plaintiff." *Blessing* v. *Freestone*, 117 S. Ct. 1353, 1359 (1997). Here, Section 1396a(a)(30)(A) does not confer benefits on providers. It therefore is unlike the Boren Amendment, which required a "system for reimbursement of providers." *Wilder*, 496 U.S. at 510. As the district court below properly observed (Pet. App. B15), Section 1396a(a)(30)(A) "was enacted as a cost-containment measure" to *limit* Medicaid payments. Indeed, respondents conceded below that Section 1396a(a)(30)(A)'s requirements that payments be consistent with "economy" and "efficiency" serve to limit Medicaid payments and do not confer on providers a right to a minimum payment. See Appellants' C.A. Reply Br. 3. Respondents instead argue that the requirement that payments be sufficient to ensure "quality care" confers on hospitals a right to cost-based Medicaid payments. Br. in Opp. 14-16. The more natural reading of the statutory requirement that payments be "consistent with * * * quality care," however, is that it is intended to benefit the needy individuals who qualify under the Medicaid program. Cf. *Arkansas Medical Society, Inc.*, 6 F.3d at 526 ("The equal access provision is indisputably intended to benefit the recipients by allowing them equivalent access to health care services.").[8] Compare *Blessing*, 117 S. Ct. at 1360-1361 (statutory requirement that State be in substantial compliance with child-support enforcement program requirements was not intended to benefit individual children or confer rights on them).

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[8] The history of Section 1396a(a)(30)(A) supports the conclusion that the equal access provision was intended to benefit Medicaid beneficiaries, not providers. See H.R. Rep. No. 247, 101st Cong., 1st Sess. 391 (1989) ("The question which the Secretary must ask is whether Medicaid beneficiaries have access to provider services that is at least as great as that of others in the area.").

Moreover, by reading Section 1396a(a)(30)(A) to confer enforceable rights on providers to payments that are "consistent with efficiency, economy, and quality of care," the court below (Pet. App. A19) has created a right that is "beyond the competence of the judiciary to enforce." *Wilder*, 496 U.S at 509 (quoting *Golden State Transit Corp.* v. *Los Angeles*, 493 U.S. 103, 106 (1989)). Neither the Act nor any regulation promulgated by the Secretary "gives any guidance" (*Blessing*, 117 S. Ct. at 1362) as to what portion of costs must be reimbursed by States for how many of the providers, or gives more specific content to the statutory criteria of "efficiency, economy, and quality of care" so that those general criteria could be enforced by a court. Accordingly, "the right assertedly protected by the statute is * * * so 'vague and amorphous' that its enforcement would strain judicial competence." *Id.* at 1359 (quoting *Wright* v. *Roanoke Redevelopment and Housing Authority*, 479 U.S. 418, 431-432 (1987)).

b. Despite petitioner's position that Section 1396a(a)(30)(A) does not confer rights on providers that may be enforced under 42 U.S.C. 1983, petitioner did not preserve that issue in the court of appeals. Although petitioner argued to the district court that respondents could not bring suit under Section 1983, petitioner did not raise the issue as an alternative ground for affirmance in the court of appeals after prevailing on the merits of the statutory question. See *Northwest Airlines, Inc.* v. *County of Kent*, 510 U.S. 355, 364 (1994). The court of appeals therefore did not address that threshold question.

Petitioner contends (Reply Br. 3) that she argued in the court of appeals that Section 1396a(a)(30)(A) was not intended to benefit providers, and that that provision lacks sufficient guidance to create judicially enforceable standards. Petitioner advanced those contentions, however, in support of her arguments on the merits regarding the

proper interpretation of Section 1396a(a)(30)(A). Petitioner did not further argue that, in light of those factors, Section 1396a(a)(30)(A) does not even create rights enforceable under 42 U.S.C. 1983. In circumstances such as these, the Court would ordinarily decline to review the issue. See, *e.g.*, *Youakim* v. *Miller*, 425 U.S. 231, 234 (1976) ("[o]rdinarily, this Court does not decide questions not raised or resolved in the lower court"); accord *Citizens Bank of Maryland* v. *Strumpf*, 516 U.S. 16, 21 n.* (1995); *Delta Air Lines, Inc.* v. *August*, 450 U.S. 346, 362 (1981); *Adickes* v. *S.H. Kress & Co.*, 398 U.S. 144, 147 n.2 (1970).

3. a. The statutory question at issue in this case—whether States must reimburse hospital providers for their costs of providing outpatient care—could have significant consequences for the Medicaid program. By ordering a system of cost-based reimbursement for outpatient services, the decision below frustrates the intent of Congress to accord States flexibility in encouraging efficient and economical care. In addition, depending upon what measure of "costs" the court of appeals meant to be reimbursed, the decision below could increase substantially the expense of the Medicaid program to the States and the federal government, without any corresponding finding that, under the current system, needy individuals lack access to quality care. See Pet. App. A17. Similarly, whether respondents may bring suit under Section 1983 is an important question that could have a significant impact on the Medicaid program. If providers such as respondents could routinely bring suit in federal court alleging that a State has failed to make adequate reimbursement to them for particular outpatient services, the cost of the Medicaid program could substantially increase, to the detriment of both the state and federal governments, and the ultimate detriment of Medicaid recipients. Thus, at some point, the

questions presented in this case may warrant this Court's review.

In our view, however, this case would be an inappropriate vehicle for plenary review of the court of appeals' decision on the merits, because the substantial threshold issue of the availability of a cause of action under 42 U.S.C. 1983 has not been addressed below or preserved for the Court's review. That conclusion is particularly warranted here, since many of the issues underlying a determination of whether 42 U.S.C. 1983 confers a right of action on providers, such as whether providers are the intended beneficiaries under Section 1396a(a)(30)(A) and the degree of flexibility conferred on the States by that Section, overlap with the statutory question of whether Section 1396a(a)(30)(A) confers on hospitals a right to Medicaid payments that reimburse all or substantially all of their costs. Thus, in our view, it would be appropriate for this Court to defer review until there is a case that adequately presents both the merits question under Section 1396a(a)(30)(A) and the threshold right-of-action question under 42 U.S.C. 1983.

b. This Court's ultimate review of both questions presented will likely benefit from further consideration by the lower courts. Although petitioner and her amici are correct in observing (Pet. 11-12; States' Amici Br. 6-7) that the Ninth Circuit's decision is in considerable tension with the decisions of two other courts of appeals regarding whether Section 1396a(a)(30)(A) requires States to adopt a particular methodology in setting Medicaid payment rates, those decisions did not squarely confront the question whether States must reimburse providers' costs in order to comply with that Section. See *Methodist Hospitals, Inc.*, 91 F.3d at 1030; *Minnesota Homecare Ass'n*, 108 F.3d at 918. The courts below did not have the benefit of the views of the Secretary of Health and Human

Services set forth in this brief concerning the interpretation of Section 1396a(a)(30)(A) on that question. Compare *Auer* v. *Robbins*, 117 S. Ct. 905, 911-912 (1997). And the precise scope of the Ninth Circuit's decision in this case is uncertain, for it is not clear what measure of "costs" the court intended that petitioner must allow the hospitals to recover. See Pet. App. A13-A15, A18, A19, A21-A22; page 15, *supra*.

Similarly, those courts of appeals that have construed Section 1396a(a)(30)(A) as conferring rights enforceable under 42 U.S.C. 1983 have not considered the issue in the specific context of a challenge to a State's plan based on its lack of consideration of providers' costs. See, *e.g. Visiting Nurse Ass'n of North Shore, Inc.*, 93 F.3d at 1000 n.3 (providers challenged State's proposed rate changes as violating "equal access" provision); *Methodist Hospitals, Inc.*, 91 F.3d at 1029 (providers argued that State could not change rates without demonstrating effect on access to care); *Arkansas Medical Society, Inc.*, 6 F.3d at 531 (providers and recipients challenged proposed reimbursement rate reductions as based on budgetary concerns without considering reduction's impact on efficiency, economy, and quality of care, as well as equality of access).

The courts of appeals also have not explored new authority bearing on a plaintiff's right to enforce "state plan" requirements set forth in the Social Security Act through an action under 42 U.S.C. 1983. The Court has recently clarified those standards in *Blessing*, 117 S. Ct. at 1359-1362. In addition, Congress recently enacted legislation concerning the scope of 42 U.S.C. 1983 actions under 42 U.S.C. 1983 to enforce provisions of the Social Security Act. See 42 U.S.C. 1320a-2, 1320a-10; Pet. App. B7-B9, note 3, *supra*. Neither the decision below nor any of the other appellate decisions construing Section 1396a(a)(30)(A) has addressed that new provision.

Finally, since the decision below was rendered, Congress, in the Balanced Budget Act of 1997, has repealed the Boren Amendment (which required States to set rates that "meet" the costs that must be incurred by reasonably efficient hospitals for *inpatient* services and was found in *Wilder* to confer rights on hospitals enforceable under 42 U.S.C. 1983) and replaced it with a more limited requirement that States provide for public notice-and-comment participation in their ratemaking processes. See Pub. L. No. 105-33, § 4711, 111 Stat. 507-508. The legislative history of that recent enactment establishes Congress's firm determination both to free the States from federal regulation and increased rates and to eliminate a basis for causes of action by hospitals to challenge reimbursement rates.

Thus, the House Report on the repeal of the Boren Amendment noted that "[a] number of Federal courts have ruled that State systems failed to meet the test of 'reasonableness' and some States have had to increase payments to these providers as a result of these judicial interpretations." H.R. Rep. No. 149, 105th Cong., 1st Sess. 590 (1997); accord H.R. Conf. Rep. No. 217, 105th Cong., 1st Sess. 867 (1997).[9] The House Report further stated that "[i]t is the committee's intention that, following enactment of this Act, neither this nor any other provision of Section 1902 [of the Social Security Act, 42 U.S.C. 1396a] will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive." H.R. Rep. No. 149, *supra*, at 591. Yet under the decision below, Section 1396a(a)(30)(A)—

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[9] States had sought repeal of the Boren Amendment on the ground that "courts have interpreted [it] to embody a restrictive and unrealistic set of requirements in setting reimbursement rates and have in effect given judges the power to establish reimbursement rates levels and criteria." National Governors' Association Policy, EC-8 Medicaid § 8.3.3 (February 1997).

which applies to medical services generally—would require States to conform to federal standards of reasonable costs and would subject them to causes of action that could lead to increased costs, not only for the outpatient services involved in this case, but also for the very same inpatient services that were previously covered by the Boren Amendment. The lower courts should be afforded the opportunity in the first instance to consider the significance of this recent enactment for the interpretation of Section 1396a(a)(30)(A) and for the availability of a cause of action under 42 U.S.C. 1983 to enforce it.

CONCLUSION

The petition for a writ of certiorari should be denied. In the alternative, the Court may wish to grant the petition, vacate the judgment below, and remand the case to the court of appeals for further consideration in light of *Blessing* v. *Freestone*, 117 S. Ct. 1353 (1997); Section 4711 of the Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 507-508; and the position taken by the Secretary of Health and Human Services in this brief.

Respectfully submitted.

SETH P. WAXMAN
Solicitor General
FRANK W. HUNGER
Assistant Attorney General
EDWIN S. KNEEDLER
Deputy Solicitor General
LISA SCHIAVO BLATT
Assistant to the Solicitor General
ANTHONY J. STEINMEYER
JEFFREY CLAIR
Attorneys

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